The Habit

ALCOHOL AND DRUG ABUSE DIVISION
MONTANA DEPARTMENT OF INSTITUTIONS
1539 11TH AVENUE, HELENA, MONTANA 59620

HABIT CERTIFICATION

A.D.A.D. recently submitted a request for an addition to the Administrative Rules of Montana covering certification. This new rule defines the taped work sample role play and is worded as follows:

"A role play shall mean a spontaneous exchange between the counselor and the person playing the part of the client. Reading from a prepared script will not be considered a test of counselor competency."

Once more we request that you submit your tapes several days in advance of the review date. In March we received 10 tapes after the reviews had begun and 4 of these were received the afternoon of the last day. In the future your tape will not be judged if it is received later than five (5) days before the scheduled review. We cannot schedule review panels and the number of days required if we do not know how many tapes we will have. We ask your cooperation.

Your change of address and your change in employment is vital to your certification records. Please keep us informed of changes so that we can contact you as well as provide you with employment credit.

Soon to be Released

N.I.A.A.A. national minimum standards for chemical dependency counselor certification. We will inform you of this development as soon as possible.

Certificates

There are still quite a large number of certificates that bear the old alcoholism or drug counselor designation; in order to have yours changed to the official "chemical dependency counselor" you must mail it to the certification section. A.D.A.D., 1539 11th Avenue, Helena, MT 59620.

Certified Since January/February Habit

225	Conn, Robert	Chemical Dependency
226	Tipton, Gary	Chemical Dependency
227	Sjolie, Bruce	Chemical Dependency
228	Jacobson, Linda	Chemical Dependency
229	Moy, Barbara	Chemical Dependency
230	Clague, Claudia	Chemical Dependency
231	Cochran, Billy	Chemical Dependency
232	Wade, Jolene	Chemical Dependency
233	Massey, Gwen	Chemical Dependency
234	Penn, Deanne	Chemical Dependency
235	Judge, Carol	Chemical Dependency
236	Kestel, John	Chemical Dependency
237	Hayes, Mary Ann	Chemical Dependency
238	Quinn, Andrew	Chemical Dependency
239	Gibbs, Scott	Chemical Dependency
240	Madman, Gary Mike	Chemical Dependency
241	Osterhout, Patricia	Chemical Dependency
242	Lundgren, Arlayne	Management/Supervision
243	Barrett, Edward	Chemical Dependency

243 Certified 975 Registered

Certification Rule Change Notice

1. On May 28, 1984, the Department of Institutions proposes to amend rule 20.3.415 which sets forth definitions which relate to the certification system for chemical dependency personnel.

2. The rule as proposed to be amended provides as follows:

(20) Role play For the purpose of the taped work sample, role play shall mean a spontaneous exchange between the counselor and the person playing the part of the client. Reading from a prepared script will not be considered as a test of counselor competency.

3. The addition of this definition to the certification rules will clarify one of the requirements that potential counselors must fulfill in order to qualify for certification.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendment in writing to Nick A. Rotering, Legal Counsel, Department of Institutions, 1539 11th Avenue, Helena, MT 59620, no later than May 25, 1984.

5. If a person who is directly affected by the proposed amendment wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Nick A. Rotering, Legal Counsel, Department of Institutions, 1539 11th Avenue, Helena, MT 59620, no later than May 25, 1984.

6. If the agency receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment; from the Administrative Code Committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 30 persons based on approximately 300 persons employed in state approved chemical dependency programs and 900 others who have applied for certification.

7. The authority of the agency to make the proposed amendment is based on Section 53-24-204 MCA, and the rule implements Section 53-24-204 MCA.

OTHER SIGNIFICANT RESOURCES & DEVELOPMENTS IN COUNSELOR CREDENTIALING

For further background information on relevant national and regional resources on counselor credentialing interested readers may wish to review NASADAD's August 1983 Special Report entitled "Status of National and Regional Alcoholism and Drug Abuse Counselor Credentialing Activities" -- copies of that Report are available from NASADAD for $3.00 prepaid. The three major groups whose composition, functions and activities are described in that report include the National Commission on Credentialing of Alcoholism and Drug Abuse Counselors, Inc., the Certification Reciprocity Consortium/Alcohol and Other Drug Abuse and the Southeastern Credentialing/Reciprocity Consortium. Additional significant group is the Western Region Counselor Certification/Reciprocity Consortium. This group resulted from a meeting in San Diego, California of representatives from credentialing bodies in western States. Thus far representatives from credentialing groups in seven States have signed a specific reciprocity agreement. The States involved include Arizona, California, Idaho, Montana, Oregon, Utah and Wyoming. For further information on this group contact: Robert MacConnel, Coordinator, Certification Unit, Alcohol and Drug Abuse Division, Montana Department of Institutions, 1539 11th Avenue, Helena, Montana 59620; Telephone (406) 444-2827.

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ADAD PURCHASES NEW FILMS

Name	Company
Children of Denial	ACT
Some Of The Things That Go On Out There	Leroy Peterson
Lots Of Kids Like Us	Gerald T. Rogers
You Pack Your Own Chute	Ramie Productions
A Slight Drinking Problem	Southerby

These films are now available from the State Film Library at the Department of Health and Environmental Sciences. A brief review of each film will be in the summer issue of the "Habit."

NEW STATE APPROVALS

Shodair Adolescent Program
840 Helena Avenue - PO Box 5539
Helena, MT 59601

8-bed Evaluation, 15-bed treatment
Inpatient Hospital

Director! Steve King - Phone 449-7630

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DEALING WITH TEENAGE DRINKING

"There is almost a one-to-one relationship between those kids who drink and those who have trouble with their parents," according to Dr. Ernest P. Noble, Director of the Alcohol Research Center in the Department of Psychiatry and Biobehavioral Sciences at the University of California at Los Angeles.

In an article entitled, "Prevention: Cleaning Up the Dirtiest Agent of All," appearing in the March issue of LISTEN magazine, Dr. Noble comments on some of the unique and alarming problems that alcohol is causing among America's teenagers. Prevention, he says, is of basic importance.

Dr. Noble, formerly director of the National Institute on Alcohol Abuse and Alcoholism, says we must deal with the popular misconception among young people that drinking makes a person more attractive to the opposite sex. "Alcohol is a very deceptive drug," he says, "because it makes you feel that you are really charming, but alcohol actually disrupts social communication. So if you want to be accepted by the opposite sex, alcohol is not the way to do it."

We need to make drunkenness taboo," he adds. "Drunkenness should not be an object for laughter, ridicule, or jokes. It's not a laughing matter."

Dr. Noble also discusses the problem of drunk driving. "We can't seduce young people," he says, "with terms like 'responsible drinking.'... We need to give very straight messages, unambiguous messages. Our society should move toward discouragement of drinking, particularly in our young people."

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CAFFEINE IS A DRUG

Why are grocery store shelves so heavily stocked with decaffeinated soft drinks lately? According to Dr. Patricia Mutch, professor of nutrition at Andrews University and director of the Institute for Alcoholism and Drug Dependency in Berrien Springs, Michigan, consumers are deciding against using caffeine because of more and more research findings that it is a harmful drug.

In an interview in the January 1984 issue of LISTEN magazine, Dr. Mutch discusses this and other topics related to caffeine and its effects on the human system. She points out that caffeine is a stimulant contained in coffee, tea, and even chocolate. "A person who's a 'chocoholic,'" she says "could be consuming a significant amount of caffeine."

Dr. Mutch points out that caffeine makes the heart beat faster and stronger, increases anxiety, stimulates the stomach to secrete more acid, increases levels of sugar and free fatty acids in the blood, and has a diuretic effect on the excretory system. Dr. Mutch says that it is known as a mutagenic agent; it can negatively alter genetic material. This, she says, may increase the risk of cancer.

Furthermore, "People who consume caffeine regularly develop a tolerance to it so that they don't recognize its effect on them ....Caffeine seems to be addictive," she says. "There are definite withdrawal symptoms in the individual who is no longer getting the caffeine he's used to."

And Dr. Mutch asserts that those who use caffeine to sharpen mental ability are wasting their time. "All the research," she says, "indicates that caffeine does not improve memory, comprehension, or the ability to function on a test." In fact, she says, those who use caffeine to stay awake at night and study for a test "would have been better off getting a good night's sleep."

ALCOHOL EPIDEMIOLOGIC DATA SYSTEM

U.S. APPARENT CONSUMPTION FOR CALENDAR YEAR 1982
December 1983

This report presents estimates of 1982 taxable sales of alcoholic beverages for the states. The information is derived from revenue reports of the states, supplemented by beverage industry data when necessary. Estimated apparent consumption is presented separately for beer, wine, spirits, and ethanol.

TABLE 1

U.S. APPARENT CONSUMPTION (IN THOUSANDS OF GALLONS) -- CY 1982

		SPIRITS		WINE		BEER		TOTAL	
		VOL	OH	VOL	OH	VOL	OH	OH	OH
Montana	(C)	1,546 *S	635	1,560 *W	201	25,200 *B	1,134	1,970	

OH = Absolute Alcohol (Beer - 4.5%; Wine - 12.9%; Spirits - 41.1%)
*C = Control State; L - License State
*B = Brewer's Association
*W = Wine Institute
*S = DISCUS

TABLE 2

'82 U.S. APPARENT PER CAPITA CONSUMPTION IN GALLONS OF ABSOLUTE ALCOHOL

	Drinking-Age Population	Spirits	Wine	Beer	Total	Rank
Montana	622	1.02	0.32	1.82	3.16	13

Per capita consumption is the amount of absolute alcohol (from Table 1) divided by the drinking population.

* Population 14 years and older, in thousands, based on July 1, 1982 population estimates.

TABLE 3

RANKS OF THE STATES FOR APPARENT PER CAPITA CONSUMPTION IN GALLONS OF ABSOLUTE ALCOHOL, 1979-1982

	1980 Gallons	1980 Rank	1981 Gallons	1981 Rank	1982 Gallons	1982 Rank
Montana	3.21	12	3.28	12	3.16	13

CSR, Incorporated operates the Alcohol Epidemologic Data System (AEDS) under Contract No. ADM-281-82-0003 for the Division of Biometry and Epidemiology, NIAAA, DHHS, 805 15th Street, N.W., Suite 500 Washington, D.C. 20005 (202)842-7644.

Editors note, and For Trivia Buffs:

	1980	1981	1982
1.	Nevada	Nevada	DC
2.	DC	DC	Nevada
3.	New Hampshire	New Hampshire	New Hampshire
4.	Alaska	Alaska	Alaska
5.	Wisconsin	Wisconsin	Hawaii
6.	Hawaii	Wyoming	Florida
7.	Wyoming	California	Colorado
8.	California	Hawaii	Wisconsin
9.	Colorado	Colorado	Wyoming
10.	Vermont	Vermont	Vermont
11.	Florida	Arizona	California
12.	Montana	Montana	Delaware
13.	Massachusetts	Florida	Montana

(Editors note: so much for the Montana Macho Mystique that Montana has the roughest toughest biggest two-fisted drinkers in the west - Nevada, Alaska, California, Colorado and Wyoming are always "per capita drunker.")

Per Capita consumption in gallons of absolute alcohol.

Jim McIntosh Neighbor To Neighbor

This issue's featured counselor is James "Big Jim" McIntosh, DUI Coordinator and Chemical Dependency Counselor at Flathead Valley Chemical Dependency Clinic. Jim holds counselor certificate #11. Jim is perhaps the "grandfather" of DUI programs. In November 1975, after serving the Flathead program as a Cottage Program volunteer for six months Jim was employed to set up an office and establish a DUI program in Whitefish. Jim later served as halfway house coordinator and transitional house coordinator and then was asked to re-establish and coordinate the DUI program for the county.

Jim believes the primary function of DUI programs are both a vehicle for intervention and assessment. In his particular program individuals have three intense one-to-one sessions and seven educational sessions. One unique feature of the Flathead Valley Chemical Dependency Clinic DUI program is use of a VHS with clients. Jim said it "sure helps with denial" for clients to see a replay of their performance during the balance, comprehension and coordination tests made during the booking procedure. Through cooperation and rapport with all local law enforcement agencies in the county, all tape bookings and make the tapes available to the DUI program. Jim said he thinks this mirror image of what people look and act like while intoxicated gets people's attention and they are more willing to learn while in the program.

Jim is the individual who first started Kalispell's prevention contest program (this year's contests featured in last issue) in cooperation and funded by the Flathead Beverage Wholesalers Association. Jim serves as a member of the County DUI Task Force and has been asked to design the poster to be used for its Memorial Day Weekend prevention campaign. Jim also serves the field by serving on the State Oral Examination Panel for counselor certification.

Jim is married and has been for twenty-six years, is the father of four (three girls and a son) and a very proud grandpa soon for the second time. Jim paid his dues to qualify for membership in the fellowship and came to sobriety through his wife's loving intervention of: one of you goes, Mr. Booze or you. Jim was in both outpatient and AA and after five years into sobriety had the opportunity for training by going through inpatient treatment in client status. He said this gave him tremendous insight into the recovery process and new introspection into his own recovery.

Jim loves shooting pool and dislikes hiking most because of grizzlies and age. Jim is a natural artist and for two years earned his living as an artist. "A drunk artist can always hustle a drink with a drawing". He, after years, is just now returning to art as a hobby and has a studio in the new home he and his wife recently purchased. He feels his art will help purchase the expensive toys he likes. Jim also rides 10 speed bikes, cross country skis, gardens and "is just learning" golf (remember the pool hustler hobby above if you play him). Jim moved to Kalispell when he married his wife who was from the area. He knows his "Higher Power lives there" and said if he ever leaves it will be for an area with bigger and higher mountains.

Jim says "he is very comfortable and content with his job". He hopes some day to move into the challenges of management. On the subject of client record keeping Jim said "a counselor should take personal pride in their recordkeeping as your records will serve you well later on when working with clients. If a counselor doesn't believe or understand the necessity and importance of records they should not be in the chemical dependency field".

Thanks for your service to the field Big Jim!

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WILDERNESS TREATMENT PROGRAM FEATURED

The magazine Alcoholism/The National Magazine has notified the Wilderness Treatment Program that they will be the featured program in the May/June edition. This periodical is published in Seattle and circulated nationwide. The article will focus on the unique treatment aspect of the Wilderness experience as part of an adolescent's treatment and recovery.

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NEW ADDRESS of Alcohol and Drug Problems Assn of North America (ADPA) is: Hall of the States, 444 North Capitol St. N.W, Washington, DC 20001. Phone 202/737-4340. Karst J. Besteman is executive director.

CAN ALCOHOLICS GO BACK TO "SOCIAL" DRINKING?

Misuse of alcohol - call it problem drinking, alcohol abuse, or alcoholism - is one of the major threats to health in this country. Yet, as a society, we have no clear program for dealing with the harmful effects of this drug. Many uncertainties about the nature of the problem have contributed to this unhappy situation. In his recent book, The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery (Harvard, 1983), Dr. George Vaillant has brought out important new information on, and insights into, the nature of alcoholism. We have asked Dr. Vaillant, a Professor of Psychiatry at Harvard Medical School, to discuss one of the most controversial aspects of alcoholism treatment: whether the proper goal is abstinence of a return to social drinking.

Why is there controversy about such a basic question?

This dispute exists because honorable investigators have obtained different answers, depending on how they asked the question. The debate has been passionate because the subject is terribly important, and because both sides are defending political and social viewpoints as well as attempting to solve a complex factual problem.

In brief, what has happened is this. Between 1973 and 1978, two major studies were completed and reported. One of them was conducted by a group at the Rand Corporation; the other was carried out by psychologists Mark and Linda Sobell, then at Patton State Hospital in California. Both reports indicted that certain alcoholics had successfully returned to asymptomatic ("controlled" or "social") drinking after treatment with behavioral methods. At the time this research was begun, there were several reasons for thinking that "social" drinking could be achieved by at least some alcoholics. Laboratory studies, for example, had shown that even people who seemed to be very dependent on alcohol could modify their drinking patterns in response to learning or to a change in their social environment - while in the laboratory. And questionnaire results from community studies identified people who claimed to have recovered control after a period of alcohol abuse.

Both the Rand Investigators and the Sobells alleged that, after treatment, many of the study subjects were able to control their drinking for months to years. Moreover, the Sobells found that the subjects who attempted social drinking were more successful at avoiding relapse into alcoholism than those who were trying to remain abstinent, at least in the year or two after treatment. There were, however, some serious flaws in the design of the Rand study, and its standards of "control" over alcohol use seemed rather low. More to the point, long-term follow-up has shown that the Sobell's subjects did not fare well. Within one to five years after treatment, all but one lost control over their drinking.

I have had the opportunity to study drinking behavior in two large groups of men who were followed for more than thirty years, from youth through middle age. All of these men were psychologically "normal" to begin with, but some of them lost control over their drinking for periods of time, and some became severely alcoholic. To be sure, there were men followed in this study who lost and then regained control over their drinking without having to give up alcohol altogether. These were the individuals who had developed relatively few alcohol-related problems (such as illness, blackouts, difficulty with employment) and they had not yet come to the attention of a professional who actually diagnosed them as alcoholics. By contrast, those men who had never developed more than a few alcohol-related problems, or whom a clinician had diagnosed as alcoholic, evidently had progressed too far in their illness to manage a return to asymptomatic drinking. They either became abstinent or they continued to suffer from alcoholism.

What this means is, first, that we have to believe reports from community studies showing that some alcoholics have been able to return to controlled drinking. But we also have to recognize that virtually nobody who has gone so far as to require admission to an alcohol-treatment program will be able to go back to symptom-free drinking for very long.

I don't think, however, that we should perpetuate a common error in interpreting this finding. It does not imply that there are two distinct classes of people - "problem drinkers" versus "alcoholics" - with a basically different ability to handle their drinking. There is no real difference except of degree. Individuals who recognize the early warnings of lost control and respond by taking measures to limit their use of alcohol may succeed in achieving some stability in their drinking patterns (By comparison, some cases of high blood pressure or adult-onset diabetes can be controlled if they are caught early and are effectively managed with such measures as diet and exercise. Later on, more extreme therapy may be needed.) The process of becoming dependent on alcohol begins with the first drink. Whether we avoid alcoholism is determined, in part, by our learning to control how we use alcohol - for example, only with food, only at a fixed time each day, only to celebrate, only so that we have no regrets the morning after.

(continued page 7)

Do you tell your patients that they can never drink again?

You really can't tell someone that. It's not helpful, and it may not be true. I follow the principle that Alcoholics Anonymous uses: to advise abstinence one day at a time. Alcoholics are extremely reluctant to give up the hope of taking another drink, as would be many nonalcoholics. As an analogy, someone who has never even run around the block would be horrified to be told, "You will have to jog three miles a day for the rest of your life." It makes much more sense to start with today's goal.

Some people do come to me with a clear alcohol problem but hoping they can manage the shift to social drinking. I offer them the following strategy: "Drink any day you like, but never have more than three drinks in a 24-hour period; come back in two months and let's see how you are doing." By a "drink" I mean one shot (1.5 ounces) of whiskey, one 12-ounce can of beer, or one 6-ounce glass of wine.

My experience is that nobody to whom I have given this prescription has been able to stay within it. At that point, both the patient and I get the message. They have lost the ability to control their drinking. Abstinence, a day at a time, becomes the treatment goal. But I think the exercise is worth a try. It is a structured experiment from which the alcoholic can learn about herself or himself; it helps to define the task and to cut through the denial that is a universal feature of alcoholic thinking. Alcoholism is a lifelong disease, like diabetes or high blood pressure. One has a lifetime - but potentially a shortened lifetime - with which to work.

How can those close to an alcoholic help him or her?

One of the greatest problems with relatives or close friends is that they protect the alcoholic's drinking. Like the alcoholic, they tend to deny what they know is really happening. That's the worst thing they can do. The earlier this disease is caught, the better one's chance of halting its progression.

If your own life is made painful because someone close to you has an alcohol problem, you have an alcohol problem. Your first step is to recognize that. Your second step is to go to Al-Anon, an organization of alcoholics' relatives, to learn what other people have done to get comfort for themselves and help for their relatives. Your third step is to find a professional, through Al-Anon or an alcohol clinic, and think through, very carefully, how to confront your alcoholic relative or friends and begin the treatment process. You have time. Alcoholism is never a problem of the moment; it puts the individual at risk for a lifetime, and it has to be approached as a lifelong disease.

Treatment may have to begin with a professional (alcoholism counselor, psychologist, social worker, psychiatrist, or other), but such help is by its nature scarce and expensive; it may also be somewhat counterproductive because it is likely to undermine the alcoholic's already poor sense of self-esteem. Sooner or later, and preferably sooner, the alcoholic should be induced to attend meetings of Alcoholics Anonymous (AA). There's nothing magic about AA; it may not even be altogether correct in its view of alcoholism. But that's not the point. AA is available, it's free, and it offers a behavior-modification program that even its psychologist-critics would have to respect. It provides contact with people who have succeeded in staying sober. And it offers a variety of ways to restore the alcoholic's hope and self-esteem.

At least as important as all these other features, AA provides a community of caring people whom the alcoholic has not injured in the past. One of the greatest burdens in any alcoholic's life is knowing that he or she has hurt everyone that he or she loves. The people at an AA meeting are not angry at the newly arriving alcoholic, and the alcoholic does not come into the room feeling guilty towards anyone there. This can be true of nobody in his or her family.

Individual subscriptions ($15.00 per year) and bulk subscriptions (reduced rates on 50 or more copies per month) are available. Contact THE HARVARD MEDICAL SCHOOL HEALTH LETTER, 79 Garden St., Cambridge, MA 02138 (617) 495-5234.

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ALCOHOL USE AND CANCER: Regular beer drinking may increase chances of developing rectal cancer, while drinking wine and whiskey may contribute to lung cancer, said federal study.

HOW MANY TREATMENTS IN A LIFETIME?

Have you ever heard of a limit of two courses of treatment in a lifetime for cancer? Or a limit of two courses of treatment in a lifetime for heart disease?

Cost containment in the health care industry is an increasingly popular topic. Chemical dependency has become a very visible cost-cutting target because, we suspect, it is still not fully accepted as a legitimate disease or condition. We think this indicates that, as a culture, we still tend to moralize about chemical dependency. Once again, the powers-that-be in charge of cost-cutting can cut more out of chemical dependency treatment than they would be allowed to cut from treatment of other illnesses.

Various methods have been used to reduce expenditures for chemical dependency treatment, such as limiting the number of days; establishing a maximum length of stay; or by arbitrarily setting a 14-day length of stay, etc. These various approaches to cost containment often fail to consider that we do need all of the levels of care presently available. The treatment needs of individuals vary a great deal.

Now a new idea has surfaced -- that of not only limiting the number of days of treatment, but also of limiting the number of courses of treatment one might undergo in a lifetime. One proposal afoot would limit the number of treatments to twice in a lifetime.

Anyone who is personally or professionally familiar with chemical dependency is well aware that it is a chronic condition in which patients are prone to relapse. But aren't heart disease and cancer patients prone to relapse? We are all familiar with individuals who are sober today, but who, in their past, probably have had three or more courses of treatment for chemical dependency. Those same individuals will tell you that they would probably be dead if they hadn't been able to avail themselves of their last course of treatment.

Consider some special populations. As a result of public education, more young people are seeking treatment for chemical dependency earlier in life. If a relapse should occur one or more times in the 50 or 60 years they have ahead of them, should they be excluded from treatment because they sought it early in their lives?

Consider older people facing the difficult life transitions involved in retirement. Such people passing through critical life stages are prone to relapse as well. Shouldn't we consider that before putting an arbitrary cap on the number of treatments available?

Through the emergence of employee assistance programs over the last decade, employers now allow the same benefits for chemical dependency as are available for other illnesses. The options for paid sick leave and unpaid medical leave of absence allow employees a great deal of flexibility in getting the necessary treatment they need for any disease.

If employers can administer fair and equitable sick leave programs for all diseases, then why can't we do the same for chemical dependency, without an arbitrary cap imposed on the number of treatments allowed in a lifetime?

Reprinted from Hazelden "Professional Update October 1983, Vol. 2, Number 2.

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ABSTINENCE BEST PREVENTION ONLY HANGOVER RELIEF

A panel of medical experts that studied hangover cures and sobriety products for the Food and Drug Administration found no remedies. The panel, according to an article in the FDA Consumer for December-January, was only able to recommend the use of products with a combination of ingredients (pain relievers for headaches, antacids for gastric distress, and caffeine for fatigue or dullness) for relief.

The panel, after examining over-the-counter drugs for relieving or minimizing hangover or preventing inebriation, could identify no product or single ingredient that is "unique in relieving the symptoms of hangover." The group also was unaware of any ingredient that "can entirely prevent inebriation."

The panel found activated charcoal safe for use but urged clinical studies to demonstrate effectiveness in minimizing the symptoms of a hangover.

Although studies submitted to the panel indicated that fructose had an effect in lowering blood alcohol levels, the panel concluded there was not enough data to show any clinical significance in minimizing inebriation and recommended further research.

Just When You Knew You Heard Them All

Drinkless Drunkeness

Charlie Swaart never took a drink but was often drunk. It took Charlie over 20 years and a trip from Phoenix to Tokyo to learn why.

He was the first non-Japanese to show up with meitei-sho, the Japanese drunkenness disease. The cause: His gut functioned as a moonshine still, manufacturing booze from carbohydrates he innocently ate.

His symptoms began while he served with U.S. forces in Japan after World War II: baffling bouts of fall-down intoxication, booze-induced obligion and public disgrace. The signs kept up after he returned to the States.

Meanwhile, Japanese doctors cured a man plagued for years by strange symptoms and unaccountable drunkenness. They found his gut swarming with a yeastlike fungus, Candida albicans, a bug that lives off carbohydrates and ferments them. Small amounts of it are normal in the intestines of three out of five people, but too many make a disease. Antibiotic treatment knocked out the Candida, and the man sobered up, even though he kept eating carbohydrates.

Japanese doctors have since amassed hundreds of cases of meitei-sho. They believe that the atomic blasts at Hiroshima and Nagasaki prompted mutations in Candida that made the alcohol-producing organism prolifterate wildly in people who harbored it. They have diagnosed the disease in three generations since 1945.

In Charlie Swaart's case, Japanese experts found 67 times the usual number of Candida colonies in his gut - enough to produce alcohol in staggering quantities. Antifungal drugs have stopped the bouts of meitei-sho.

Oddly, nothing about meitei-sho has appeared in Western medical journals. Charlie's wife wonders: "There've been thousands of Americans stationed in Japan. I just can't believe that Charlie was the only one who picked up this form of Candida." Maybe he wasn't.

Reprint from "American Health Fitness of Body and Mind" published by American Health Partners, P.O. Box 10034, Des Moines, IA 50347 (six issues $9/year)

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INSURANCE
New York State Insurers To Provide Coverage For Families of Alcoholics

"A modified version of the Governor's Program Bill on Alcoholism Insurance passed both houses of the New York State Legislature and the Governor will soon be signing it," said Robert A. Ross, Acting Director of the New York State Division of Alcoholism and Alcohol Abuse.

Ross continued, "The legislation requires all insurers, including Blue Cross, to provide coverage of up to twenty (20) outpatient visits for families of alcoholics."

In conclusion Ross said, "The passage of this legislation was accomplished largely because of the overwhelming support that was communicated to the legislature and the Governor by members of the alcoholism constituency. While it is not everything we hoped for it is a major step in the direction of providing reimbursement for the appropriate level of care to those insured individuals requiring alcoholism services."

For additional information contact: New York State Division of Alcoholism and Alcohol Abuse, 194 Washington Ave., Albany, NY 12210. (518) 474-3377.

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WORKPLACE DRINKING: Called problem that isn't going away, alcoholics have five times average number of workers compensation claims and their accident and hospitalization rates are three to four times higher, according to Journal of Amer Insurance.....Although 37 states have mandated that health ins carriers offer alcoholism treatment benefits, workers' coverage is still minimal. One reason for low incidence of coverage is that some of the more populous states haven't mandated the benefit. Also, self-insurers aren't required to follow laws and about half of the 37 states require only optional alcoholism treatment coverage. Many states require that carriers include alcoholism treatment coverage in health care packages for new policyholders only. Details available from editor.

BOOK REVIEWS

(For Bashes, Beaches, BBQ's and Birthdays)

Drinks Without Liquor

by

Jane Brandt

Sample:

STRAWBERRY SLIM

A pretty drink with a delicate taste and a delicate color. It's perfect for any time of the day.

2 cups fresh ripe strawberries
½ cup club soda
½ pint low-calorie vanilla ice cream or 1 8-ounce container of vanilla yogurt
½ cup skim milk
Garnish: Extra mint leaves

1. Wash and hull the strawberries.
2. Place all the ingredients, through the milk, in a blender and blend 1 minute until smooth.
3. Serve garnished with whole mint leaves.

Servings: 4 tall glasses

SPICY DIET ICED COFFEE

Drink this occasionally if you're counting those little calorie devils, or all summer long if you're just plain thirsty and love the taste of coffee.

3 cups strong hot coffee
1 cinnamon stick
3 whole cloves
¼ teaspoon ground allspice
Artificial sweetener to taste
Garnish: Orange-peel strips

1. Pour coffee into a bowl or pitcher and stir in the cinnamon stick, cloves, and allspice. Let stand for 2 hours.
2. Remove the cinammon stick and the cloves and serve over ice in tall glasses. Add artificial sweetener to taste and garnish each serving with a strip of orange peel.

Servings: 4 tall glasses

This book is a must for anyone who thinks recovery limits one to coffee, sodapop and cranberry juice. Pages and pages of fun recipes and fun funny party toasts. "From Drinks Without Liquor c 1983 by Jane Brandt, Workman Publishing, New York. Reprinted with permission of the publisher."

DRINK THE WINDS, LET THE WATERS FLOW FREE

By Pat Panagoulias and Sharon Day-Garcia. A new book from the Johnson Institute for American Indians who are recovering from alcoholism. Directed and written by three American Indians (the two authors and Sam Gurnoe, a consultant) the book contains reflections, poems, prayers, and drawings - some written by the authors, others passed down through generations - that reflect the spirituality and culture of the American Indian people. Drink the winds, Let the water flow free expresses not only the pain and sadness of alcoholism, but also the hope, joy, and freedom of recovery. Conrad Balfour was a special advisor for the project. The cover and illustrations were done by Jaune Quick-To-See Smith.

40 pages $ 4.95

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DR. ERNEST P. NOBLE, formerly director of NIAAA, says we must deal with popular misconception among young people that drinking makes a person more attractive to the opposite sex. "We can't seduce young people with terms like 'responsible drinking'...We need to give very straight messages, unambiguous messages. Our society should move toward discouragement of drinking, particularly in our young people."

SEN PAULA HAWKINS, R-FL, who chairs Senate Subcommittee on Alcoholism and Drug Abuse, pushing hard to bring to justice four close aides to Fidel Castro who've been indicted on drug smuggling charges and remain at large....Senate Foreign Relations Committee passed amendment introduced by Sen Hawkins, calling on President Reagan to find ways to extradite the four Cubans and one Colombian. The Hawkins amendment also asks Reagan administration to use America's communication resources to inform Cuban people of their government's role in international drug trafficking.

Federal Research Grant Available

1. Alcohol and Work or School-Based Issues.

2. Prevention (research focused on reducing the incidence and prevalence of alcoholism and alcohol-related problems).

3. Early Identification and Diagnosis.

4. Treatment Assessment and Service Research (innovative treatment approaches).

5. Psychosocial: cognitive effects of alcohol abuse, the social and cultural differences in alcohol consumption, and the role of drinking in relation to accidents, violence and crime.

Copies of the Federal announcement are available from ADAD; how the Fed offered the following advice: "although not mandatory, applicants desiring support under this announcement are encouraged to consult with program staff of NIAAA prior to official submission of an application. Inquiries should be made to the Division of Extramural Research, Room 14C-17, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301)443-4223.

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NEW FACE

Harvey Uken, Jr. is the counselor at the Alcohol and Drug Counseling Center of Mineral County in Superior, MT. 59872 Office # 822-4421. He comes from Wyoming State Children's Home in Casper where he was a supervisor/A/D counselor and developed an A & D program for that institution.

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ADAD STAFF CHANGES

Mike Murray is no longer with the Department of Institutions or ADAD. During his twelve year tenure with the Department he was employed with many different titles, all related to the chemical dependency field. Mike has left government service and with his wife, Helen, purchased Action Print in Helena. We wish him success in his new endeavor and hope he earns great sums of money; but doesn't "make any" on his press.

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QUOTE TO NOTE: "Like any other growth industry (the drug business) is run by men of ambition and vision, by executives and entrepreneurs, often from the middle class, backed up by a full complement of bankers, lawyers and financiers. Stimulated by their enormous, and untaxed profits, they keep a sharp eye on growth rate, territorial expansion and market share." -- Mathea Falco, New York Times Magazine.

LIST OF STATES WHICH ENACTED BASIC PROVISION OF Uniform Alcoholism and Intoxication Treatment Act, decriminalizing public drunkenness and approaching alcoholism as a health problem, available from National Institute on Alcohol Abuse and Alcoholism.

MEN TWICE AS LIKELY as women to die of acute alcoholism and acute alcohol poisoning, reported Center for Disease Control (CDC). The median age at death from alcoholism, for both sexes, is 50.

ANHEUSER-BUSCH to test market new product dubbed "L.A. from Anheuser-Busch," which will include 2% alcohol (about half that of regular beer) and contain fewer calories (between 85 and 90) than many light beers now on market.

HARD EVIDENCE has surfaced that Vietnam is growing opium to help cover its debts, according to article published by Wall Street Journal.

350 copies of this publication were produced at a unit cost of $ .41 per copy, for a total cost of $143.50 which includes $112.70 for printing and $30.80 for distribution.